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In the Supreme Court of the United States

DAVID KING, ET AL., *Petitioners,*
v.
SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., *Respondents.*

On Writ of *Certiorari* To The United States Court of Appeals For the Fourth Circuit

Brief of *Amici Curiae* AARP, National Health Law Program, Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders, and National Council On Aging In Support of Respondents Urging Affirmance

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INTERESTS OF *AMICI*[1]

AARP is a nonprofit, nonpartisan organization with a membership that strengthens communities and fights for the issues that matter most to families such as health care, employment, income security, retirement planning, affordable utilities and protection from financial abuse. Since its founding in 1958, AARP has advocated for quality, affordable, and accessible health care as well as controlled health care costs. In response to the growing number of older people who lacked health care services or faced financial burdens due to unaffordable and inaccessible insurance and other health care costs, AARP sought legislative reforms that would, among other objectives: guarantee access to affordable health insurance for people ages 50 to 64 who were priced out of the individual market due to their age, preexisting conditions, or health status; and help low- to moderate-income older adults receive assistance with premiums and other health care costs.

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved people. For over forty years, NHeLP has worked to help individuals and advocates

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[1] Counsel for the parties filed notices of consent to the filing of *amicus curiae* briefs in this case. No counsel for any party authored this brief in whole or in part. No person or entity aside from *amici* or its counsel made a monetary contribution to support the preparation or submission of this brief.

overcome barriers to health care, including lack of affordable services.

Services & Advocacy for GLBT Elders (SAGE) is the largest and oldest national organization dedicated to improving the lives of lesbian, gay, bisexual and transgender (LGBT) older adults. Founded in 1978, SAGE coordinates a network of affiliates across the country, offers supportive services and consumer resources for LGBT older adults and their caregivers, advocates for public policy changes that address the needs of LGBT older people, and provides training for aging providers and LGBT organizations. Many LGBT older adults across the country struggle to find affordable and culturally competent health care—placing them at a significant disadvantage when they are most vulnerable. SAGE is committed to ensuring that the Patient Protection and Affordable Care Act (ACA or "the Act") protects the ability of all older adults to age with security and dignity.

For 65 years, the National Council on Aging (NCOA) has been a respected national leader and trusted partner to help people aged 60+ meet the challenges of aging. Our mission is to improve the lives of millions of older adults, especially those who are struggling. Through innovative community programs and services, online help, and advocacy, NCOA is partnering with nonprofit organizations, government, and business to improve the health and economic security of 10 million older adults by 2020. NCOA's Center for Benefits Access helps community-based organizations find and enroll seniors and

younger adults with disabilities with limited means into benefits programs for which they are eligible, so they can remain healthy, secure, and independent.

Amici have supported the ACA and the access to affordable health insurance it provides for millions of individuals. Premium tax credits under the ACA are critical to affordability and, thus, access to needed health care services. *Amici* are interested in the issues raised by this case, and write to provide additional information about how the Act's statutory provisions work together to achieve its overarching purpose and how the Petitioners' theory of statutory construction squarely contravenes that purpose and harms vulnerable people—in particular older adults. The Parties and other *amici* have not addressed the impact of premium tax credit assistance on older adults' ability to obtain adequate and affordable health insurance and on their lives.

SUMMARY OF ARGUMENT

The overarching purpose of the ACA is to address the lack of adequate and affordable health insurance and, thus, access to health care—a complex social and economic problem that affects all, but can be especially challenging to those ages 50 to 64 (hereinafter "pre-Medicare adults"). Pre-Medicare adults faced special difficulties in obtaining adequate and affordable health insurance in the nongroup and employer-based markets and generally did not qualify for publicly funded insurance.

Prior to the passage of the ACA, pre-Medicare adults were denied coverage based on preexisting conditions or health status or offered costly policies that excluded coverage for needed care. When coverage was available, insurance premiums for older adults were up to seven times higher than those for younger adults. Annual and lifetime caps—easily exceeded by treatment for a single illness such as cancer or heart disease—meant that many older adults either went without treatment until they became eligible for Medicare or incurred financially ruinous medical debt. Lack of adequate insurance among this pre-Medicare group resulted in worse health outcomes, including death, and negatively impacted personal finances, health care spending, federal programs, and the national economy.

The ACA reflects Congress' chosen policies to address these problems. Reflecting a basic understanding that affordability and accessibility of health insurance in the private individual market required a larger and more diversified insurance risk pool, key reform provisions of the ACA are designed to encourage people to obtain health insurance and to reduce barriers to coverage. Among these interconnected reforms is the availability of federal tax credits to reduce premiums for individuals who buy insurance on the Exchanges.

Petitioners' argument that Congress intended to provide premium tax credits only to individuals in states that established an Exchange is inconsistent

with the text and structure of the Act[2] and is directly at odds with its purpose, as expressed by Congress and manifested in its interconnected reforms. Petitioners' acontextual interpretation of a single phrase in one provision of the Act—if accepted—will make insurance unaffordable in the 34 states that use the Federally Facilitated Exchanges,[3] harming low- to moderate-income residents of those states. It would also render meaningless other key provisions of the ACA designed to increase access to affordable health insurance for *all*.

ARGUMENT

I. Before the ACA, Health Insurance Was Unavailable or Unaffordable to Millions of Pre-Medicare Adults.

Before implementation of the ACA, the number of uninsured Americans aged 50 to 64, grew at an alarming rate—increasing from 5.2 million in 2000, to 7.1 million in 2007, and then to 9.2 million in 2012. *See* Gerry Smolka et al., AARP Pub. Policy Inst., *Health Care Reform: What's at Stake for 50- to 64-Year Olds?* 1 (2009) [*What's at Stake*]; Gerry

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[2] Amici adopt and incorporate by reference Respondents' arguments regarding statutory construction of the ACA.

[3] Individuals may purchase health insurance policies via 27 Federally Facilitated Marketplaces and 7 State-Partnership Marketplaces. *See* Kaiser Family Found., *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion* (Jan. 27, 2015), http://goo.gl/NmpIrG (last visited Jan. 28, 2015) [State *Decisions*]. *Amici* refer to these 34 Marketplaces collectively as "Federally Facilitated Exchanges."

Smolka et al., AARP Pub. Policy Inst., *Effect of Health Reform for 50-to 64-Year-Olds* 1 (2013) [*Effect of Health Reform*]. Most uninsured pre-Medicare adults did not have access to affordable employer-sponsored insurance, could not afford private insurance on the individual market, or did not qualify for publicly funded insurance programs. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts about the Uninsured Population* 2 (2013). The consequences for these individuals, their families, and the nation were devastating.

A. Employer-Sponsored Health Insurance Was Frequently Unavailable or Unaffordable.

For many pre-Medicare adults, employer-sponsored insurance was unavailable or unaffordable. In 2012, an estimated 11 million *employed* pre-Medicare adults did not have employer-sponsored insurance. *Effect of Health Reform*, *supra*, 2. Of these, less than half were able to obtain coverage from another source. *Id.* The unavailability of employer-sponsored insurance for pre-Medicare adults was driven, in part, by the economic recession, during which this group experienced rising rates of unemployment. *See* Sara R. Collins et al., The Commonwealth Fund, *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable Care Act of 2010*, at 2 (2010) [*Realizing Health Reform's Potential*]. Pre-Medicare adults went without employer-sponsored insurance for longer than their younger counterparts because, on average, they remained unemployed for longer periods of time. *Id.*

As of December 2013, for example, adults ages 55 and older remained unemployed for an average of 11.6 weeks longer than their younger counterparts. *See* Sara E. Rix, AARP Pub. Policy Inst., *The Employment Situation, December 2013: Disappointing Year-End Numbers for Older Workers* 4 (2014).

B. Health Insurance on the Individual Private Market Was Unaffordable or Inadequate.

Prior to ACA reforms, many pre-Medicare adults could not afford adequate insurance policies on the private individual market. In 2007, 61% of pre-Medicare adults who tried to purchase health insurance on the private market found it unaffordable. *See Realizing Health Reform's Potential*, *supra*, 5 ex. 4. Among those who purchased insurance, 60% reported difficulty paying medical bills or accessing services due to cost such that they were effectively underinsured. *Id.* 6 ex. 5. High health insurance premiums, high out-of-pocket medical expenses, and lack of coverage for older adults were linked to insurance underwriting policies that allowed insurers to deny coverage or charge higher premiums based on age and/or health status, offer very limited policies to people with preexisting conditions, or offer policies with comprehensive coverage but prohibitively expensive premiums and/or cost sharing. *See* Elizabeth Abbott et al., *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers* 10-13 (2012); Lynn Nonnemaker,

AARP Pub. Policy Inst., *Beyond Age Rating: Spreading Risk in Health Insurance Markets* 2-3 (2009) [*Beyond Age Rating*]. Pre-Medicare adults were disproportionately affected by these underwriting policies because 48 to 86% of people ages 55 to 64 had preexisting health conditions. U.S. Dep't of Health & Human Servs., *At Risk: Pre-Existing Health Conditions Could Affect 1 in 2 Americans* 3 fig. 1 (2011).

ACA reforms prohibit or limit these practices. *See, e.g.*, 42 U.S.C. § 300gg(a) (2012) (premiums may not be based on health status); 42 U.S.C. § 300gg-1 (2012) (guaranteed issue in individual and group markets); 42 U.S.C. § 300gg-2 (2012) (guaranteed renewal). These reforms prohibit insurance companies from denying coverage based on preexisting conditions, disability, or other information related to health status such as genetic predispositions or past medical expenses. *See* Kaiser Family Found., *Health Insurance Market Reforms: Guaranteed Issue* (2012), http://goo.gl/9d4Sk7. Yet, even after the passage of the ACA, challenges remain for pre-Medicare adults shopping for health insurance in the private market because they still face higher premiums than their younger counterparts. *See* 42 U.S.C. § 300gg(a)(1)(A)(iii) (permitting age rating ratio of 3:1). As a group, however, they are no better able to afford higher premiums than other age groups. An analysis of the March 2008 Current Population Survey revealed that the median income for the uninsured ages 50 to 64 was roughly equal to the median income of their younger counterparts. *Beyond Age Rating*, *supra*, 3

tbl. 1. Moreover, the Great Recession worsened the financial outlook for households led by people between ages 55 and 64, whose median household income declined by 6.4%—the largest percentage decrease among all age groups. *See* Press Release, Sentier Research, *Household Income Down by 3.1 Percent Overall Post Recession, But Many Groups Have Started to Recover Following 2011 Low-Point* 1 (2014), http://goo.gl/cU2BSf. Federal assistance with insurance plan premiums and out-of-pocket costs is, therefore, critical to insurance affordability and access for pre-Medicare adults.

C. Medicaid or Medicare Was Unavailable.

Most adults ages 50 to 64 did not qualify for publicly funded insurance. In 2012, 10% of the insured ages 50 to 64 had coverage through Medicaid and 8% had some other form of public insurance such as Medicare,[4] VA, or TRICARE—representing only 13% of the total population in this age range. *Effect of Health Reform*, *supra*, 1-2, 5. Even if all states now expanded Medicaid eligibility to include adults who have incomes at or below 138% of poverty, less than one third of the 13.8 million pre-Medicare adults who were on the individual health insurance market or uninsured in 2012 would be eligible for Medicaid. *Id.* 7-8 fig. 2.

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[4] In 2012, only 17% of Medicare beneficiaries were under the age of 65 because they qualified due to disability rather than age. *See* Ctrs. for Medicare & Medicaid Servs., *Medicare & Medicaid Statistical Supplement: 2013 Edition* tbl. 2.4 (2012), http://goo.gl/gYdWFW.

II. Lack of Adequate and Affordable Health Insurance Among Pre-Medicare Adults Results in Worse Health Outcomes and Death, and Negatively Impacts Financial Stability, the Health Care System, Federal Programs, and the National Economy.

A. Uninsured Pre-Medicare Adults Die or Suffer Worse Health Outcomes at Greater Costs to Them and to the Health Care System.

As people age, they are more likely to experience chronic health conditions, resulting in worse health outcomes and increased mortality for the uninsured. The prevalence of multiple chronic conditions is greater in adults ages 45 to 64 than in younger adults and, for this older population, it increased significantly between 2001 and 2010. Brian W. Ward & Jeannine S. Schiller, *Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey, 2010*, 10 Preventing Chronic Disease 1, 5 (2013). For example, adults ages 45 to 64 suffer from heart disease at a rate three times higher than younger adults. Jeannine S. Schiller et al., U.S. Dep't of Health & Human Servs., *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2010*, at 19 (2012). The Centers for Disease Control and Prevention estimates that chronic conditions are the leading cause of death and disability and that treating such conditions accounts for more than 75% of health care spending. U.S.

Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Chronic Diseases: The Power to Prevent, the Call to Control* 2 (2009). This tremendous toll on human life and on health care resources can be reduced, as many of these conditions are preventable and can be effectively controlled with preventive services and early treatment. The uninsured, however, are less likely to have access to these services. *Id.*

Uninsured pre-Medicare adults are three times less likely to be up-to-date with clinical preventive services than those who are insured. *See* Megan Multack, AARP Pub. Policy Inst., *Use of Clinical Preventive Services and Prevalence of Health Risk Factors Among Adults Aged 50-64*, at 40, 43 (2013) (32.8% of insured women were up-to-date, compared to only 10% of uninsured women; 36.1% of insured men were up-to-date, compared to only 12.4% of uninsured men). Uninsured adults are less likely to be aware of risk factors for chronic conditions and to have these conditions diagnosed, treated, or well-controlled. Inst. of Med., *America's Uninsured Crisis: Consequences for Health and Health Care*, 72-83 (2009) (comparing uninsured adults ages 18 to 64 to their insured counterparts). Consequently, uninsured adults suffer worse health outcomes, including higher mortality rates. *Id.* at 75 tbl. 3-4.

B. When Uninsured Older Adults Enroll In Medicare, They Become Healthier But Are More Costly to the Medicare System.

When previously uninsured older adults gain Medicare coverage, they experience improved health outcomes and a decreased risk of dying when hospitalized for serious conditions. *Id.* at 72. These findings suggest that uninsured pre-Medicare adults had significant unmet health needs before they enrolled in Medicare and gained increased access to prescription drugs and other medical treatments to control their illnesses. *See id.* at 77. Consequently, it is substantially more costly to treat the previously uninsured in the Medicare system than treating those who were previously insured. *See* U.S. Gov't Accountability Office, GAO-15-53, *Medicare: Continuous Insurance Before Enrollment Associated with Better Health and Lower Program Spending* 9 (2013) (Medicare spent 35% more on the previously uninsured in the first year of enrollment than on those continuously insured over the previous six years); *see also* J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 357 New Eng. J. Med. 143, 151 (2007).

Obtaining preventive services and medical treatments earlier could reduce the cost of medical and drug treatments for individuals who eventually enroll in Medicare because conditions would be diagnosed at less advanced stages and/or better controlled. *See The Instability of Health Coverage in America: Hearing Before the Subcomm. on Health of*

the H. Comm. on Ways & Means, 110th Cong. 50 (2008) (statement of Dr. John Z. Ayanian). For example, one study followed adults ages 50 to 64 until they reached the age of 75 and found that, if they received screening for colorectal cancer before enrolling in Medicare, the program could save between $7.7 and $21.7 billion in potential treatment costs. *See* Nat'l Colorectal Cancer Roundtable, *Increasing Colorectal Cancer Screening – Saving Lives and Saving Dollars: Screening 50 to 64 Year-Olds Reduces Cancer Costs to Medicare* 2 (2007). Similarly, diabetes screening for people who are 55 and older and have at least one risk factor could reduce Medicare's diabetes-related costs of care by 17.1%. Ranee Chatterjee et al., *Screening for Diabetes and Prediabetes Should Be Cost-Saving in Patients at High Risk*, 36 Diabetes Care 1981, 1984 tbl. 2 (2013). For uninsured pre-Medicare adults, however, these types of preventive and screening services and treatment for underlying conditions, are unaffordable and inaccessible.

C. Lack of Adequate, Affordable Health Insurance Among Pre-Medicare Adults Profoundly Affects Their Financial Stability and the National Economy.

The lack of adequate, affordable health insurance profoundly affects both the financial mobility and stability of pre-Medicare adults and, in turn, the national economy. Many pre-Medicare workers who relied on employer-sponsored health insurance did not leave their jobs, switch jobs, reduce their hours, or retire for fear that they would lose

and be unable to regain affordable health benefits. *See* Richard W. Johnson et al., AARP Pub. Policy Inst., *Older Workers on the Move: Recareering in Later Life* at x, 10, 18 (2009) ("Nearly a quarter of career changers lose health insurance when they change jobs; only about 10 percent gain insurance."); *see also* Sara R. Collins et al., The Commonwealth Fund, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief* 3 (2011) [*Help on the Horizon*] (nearly three fifths of adults 18 to 64 who lost employer health benefits became uninsured). Chronically ill workers, who are more likely to be older workers, were 40% less likely to leave their jobs if they had employer-sponsored health insurance compared to those who did not rely on such coverage. Kevin T. Stroupe et al., *Chronic Illness and Health Insurance-Related Job Lock*, 20 J. Policy Analysis & Mgmt. 525, 525 (2000). Many older workers eligible for Medicare needed to maintain health coverage for a younger spouse or dependent child and were deterred from retiring or reducing their work hours. *See* Sid Groememan, AARP, *Staying Ahead of the Curve 2007: The AARP Work and Career Study* 23 (2008) (finding that 47% of workers 62 to 74 cited the "need to maintain health insurance" as a reason to continue working). The Congressional Budget Office (CBO) projected a decrease in the number of work hours inversely related to the availability of subsidies on the Exchanges, suggesting that the availability of affordable health insurance will increase labor market mobility. *See* Cong. Budget Office, *Labor Market Effects of the Affordable Care Act: Updated*

Estimates, in The Budget and Economic Outlook: 2014 to 2024 at 121 (2014).

Health care costs were financially debilitating for those with inadequate or no health insurance. *See, e.g.*, Karen Pollitz et al., Kaiser Family Found., *Medical Debt Among People with Health Insurance* 12, 19 (2014) (profiling a 51-year-old man with household income below 400% of Federal Poverty Level (FPL)[5] and high insurance premiums that contributed to his bankruptcy). The median pre-Medicare household with a recently ill and uninsured member lost between 30 and 50% of its assets. Keziah Cook et al., *Does Major Illness Cause Financial Catastrophe?* 45 Health Servs. Res. 418, 419 (2010). More than two thirds of pre-Medicare adults who participated in the individual insurance market paid more than 10% of their income to medical costs. *What's at Stake*, *supra*, 2 tbl. 1. One study estimated that 29 million people used all of their savings on medical expenses. *Help on the Horizon*, *supra*, 12. Another 22 million were unable to pay for basic necessities such as rent, food, and utilities due to medical bills. *Id.*

These health-care-related financial burdens severely hampered retirement security for individuals and hurt the national economy as well.

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[5] The Federal Poverty Level is set by guidelines based on poverty thresholds and used to determine eligibility for certain federal programs. U.S. Dep't of Health & Human Servs., Office of the Assistant Sec. for Planning and Evaluation, *Further Resources on Poverty Measures, Poverty Lines, and Their History*, http://goo.gl/YYngxA (last visited Jan. 28, 2015).

In 2012, there were 6.3 million adults ages 65 and older living at or near the FPL. *See* U.S. Dep't of Commerce, U.S. Census Bureau, *Income, Poverty and Health Insurance Coverage in the United States: 2012*, at 14 (2013) [*Poverty*] (3.9 million living at or below the FPL); U.S. Dep't of Commerce, U.S. Census Bureau, *Living in Near Poverty in the United States: 1966-2012*, at 19 (2014) [*Near Poverty*] (2.4 million living between 100% and 125% of the FPL). The number of older adults living in financial insecurity is likely higher because the factors considered to calculate the FPL, developed 40 years ago, do not take into account a number of relevant measures of economic wellbeing such as health care costs, which increase as one ages. *See Poverty*, *supra*, 20-21 (finding that15.3 million additional people over 65 would be in poverty if social security payments were not counted as income); Dale H. Yamamoto, Soc'y of Actuaries, *Health Care Costs From Birth to Death* i (2013) (finding that health care costs increase with age). National budget deficits are worsened when lower-income pre-Medicare adults use a large share of their income on rising health care expenses, retire without savings, and find they must turn to government assistance to meet housing, food, and utility needs. *See Near Poverty*, *supra*, 15 fig. 9 (detailing the rates at which people in and near poverty received public assistance in 2012).

III. The Central and Overarching Purpose of the ACA is to Make Health Insurance and, Thus, Health Care Affordable to *All*.

The central and overarching purpose of the ACA was to address the complex problems described above by making health insurance and, thus, health care accessible and affordable to all. Congress clearly expressed this purpose in the text of the Act. Moreover, Congress made policy choices in the Act that were clearly intended to effectuate this purpose and thereby reduce the staggering burdens of lack of affordable insurance on the uninsured, the health care system, federal spending programs, and the national economy. Congress understood that health insurance affordability could only be achieved by significantly expanding and diversifying the population of insured individuals. Thus, many key provisions of the ACA, including those that authorize premium tax credits, are designed to encourage more Americans of varying health statuses to obtain health insurance. Petitioners' acontextual interpretation of a single phrase in one provision of the Act, which is only used to calculate the amount of the premium tax credit, by contrast, would have the opposite effect: discouraging participation in the insurance marketplace and raising costs.

A. Congress Clearly Expressed the Purpose of the ACA in Its Text.

The purpose of the ACA, as expressed by Congress in its text, is to achieve "near-universal coverage" and "lower health insurance premiums."

42 U.S.C. § 18091(2)(D), (I) (2012); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) (purpose of the Act is "to increase the number of Americans covered by health insurance and decrease the cost of health care"). The name of the Act—the "Patient Protection and Affordable Care Act"—reflects the purpose of the legislation, as do the names of the Titles of the ACA. *See* Pub. L. 111-148, § 1, 124 Stat. 119, 119 (2010). As one District Court noted, "Title I of the ACA is titled 'Quality, Affordable Health Care for *All* Americans.'" *Halbig v. Sebelius*, Civ. No. 13-0623 (PLF), 2014 U.S. Dist. LEXIS 4853, at *55 (D.D.C. Jan. 15, 2014).

B. Congress' Chosen Policies Were Specifically Designed to Work Together to Achieve the Goal of Making Health Insurance Accessible and Affordable to *All*.

Congress chose to accomplish "near universal coverage" and "lower health insurance premiums" through a series of statutory requirements that, working together, make coverage affordable and accessible to everyone. *See* 42 U.S.C. § 18091(2) (2012). The ACA reduces the number of uninsured by establishing incentives for individuals, states, and employers to participate in the insurance markets and provide insurance coverage. The Act also increases access to health insurance in the individual market through guaranteed issue provisions, rating limitations, and the individual mandate. Together, these provisions improve affordability because they ensure that the insurance risk pool is larger and

more diverse, and, in doing so, keep premiums down. Finally, the ACA makes insurance more affordable for low- to moderate-income individuals through tax credits to lower the cost of premiums and cost-sharing reductions to assist with out-of-pocket costs.

1. The ACA Encourages Employers to Offer Adequate, Affordable Health Insurance.

Employer-based insurance is the traditional backbone of the American health insurance system where most adults purchase coverage. Yet, in 2012, 10.8 million older workers did not have access to employer-based insurance, and 5.9 million of those workers were not able to obtain coverage from another source. *Effect of Health Reform*, *supra*, 3 tbl. 2. The ACA addresses this problem by encouraging employers to offer health insurance. The Act imposes a shared-responsibility requirement on large employers, who now face a tax penalty if they do not offer adequate and affordable insurance to their full-time employees. *See* 26 U.S.C. § 4980H(a) (2012) (penalizing large employers who do not offer affordable minimum coverage to employees); 26 U.S.C. § 36B(c)(2)(C)(i)(II) (2012) (employer-sponsored coverage is unaffordable if the employee's share of the premium for self-only coverage is more than 9.5 percent of his or her household income); 26 U.S.C. § 4980H(b)-(d) (2012) (employer is penalized after verification that it did not offer insurance that meets the defined affordability and adequacy standards). Small employers are also encouraged to provide health benefits to their employees through

the Small Business Health Options Program, which is designed to increase their buying power on the group market by making tax credits available. *See* 42 U.S.C. § 18031(b)(1)(B) (2012); 26 U.S.C. § 45R (2012) (small businesses are eligible for tax credits for health insurance expenses when low-wage workers buy health insurance through the Program).

2. The ACA Encourages Individual Participation in, and Improves Access to, the Individual Market.

For those without employer-sponsored insurance, the ACA eliminates or significantly reduces the barriers that many pre-Medicare adults previously faced in accessing affordable health insurance in the individual market. *See*, *supra*, Part I.B.; *What's at Stake*, *supra*, 5. The Act bans insurers' practice of cancelling the policies of people who became ill and requires insurers to "accept every employer and individual in the State that applies for coverage," regardless of preexisting conditions. 42 U.S.C. § 300gg-1(a); *accord* 42 U.S.C. § 300gg–12 (2012). New rating limitations prohibit insurers from charging differential premiums based on health status. 42 U.S.C. § 300gg(a)(1)(A)-(B) (2012). Though insurers may still use age-rating, premiums for older adults may not be more than three times the amount of the premium for a younger adult. 42 U.S.C. § 300gg(a)(1)(A)(iii) (2012).

To ensure that the insurance market can cover the risk of insuring more people with health conditions, the individual mandate ensures that

healthy people participate by requiring most people to purchase insurance and maintain minimum health coverage.[6] 26 U.S.C. § 5000A(a) (2012). Between guaranteed issue provisions, rating limitations, and the individual mandate, the ACA seeks to create "effective health insurance markets in which improved health insurance products can be sold" by broadening the risk pool to include people of varying health statuses. 42 U.S.C. § 18091(2)(I) (2012).

3. The ACA Makes Health Insurance in the Individual Market More Affordable.

In addition to reducing barriers to access, the ACA makes health insurance on the individual market more affordable through two principal forms of direct financial assistance to qualified individuals buying coverage offered on the Health Insurance Exchange/Marketplace: tax credits to reduce premium costs for people with incomes between 100 and 400% of the FPL, 26 U.S.C. § 36B(b)(3)(A), and cost-sharing reductions for out-of-pocket expenses for people with incomes below 250% of the FPL, 42 U.S.C. § 18071(c)(2). These forms of assistance were designed to encourage low- to moderate-income adults to purchase insurance rather than seek the unaffordability exemption or pay the shared

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[6] Adults 30 years of age and under and those who demonstrate they cannot afford coverage have the option to purchase catastrophic coverage, and everyone has the option of paying a tax in lieu of purchasing coverage. *See* 42 U.S.C. § 18022(e) (2012); 26 U.S.C. § 5000A(c) (2012).

responsibility tax.[7] H.R. Rep. No. 111-443, vol. 1, at 250 (2010) (premium tax credits "are key to ensuring people affordable health coverage"). In 2012, about 2 million people ages 50 to 64 that were in the individual market and more than 5 million who were uninsured could qualify for premium tax credits for individual coverage purchased on the Exchange. *Effect of Health Reform*, *supra*, 7.

4. The ACA Encourages States to Expand Medicaid Coverage for Low-Income Adults Who May Be Exempt From the Individual Mandate.

While individuals who cannot afford coverage even with the aid of premium tax credits are exempt from the individual mandate, 26 U.S.C. § 5000A(e)(1), states may expand their Medicaid programs so that lower income people are eligible for public insurance under the ACA. 42 U.S.C. §1396a(a)(10)(A) (i)(VIII) (2012). Prior to the ACA, low-income adults without dependent children were not eligible for Medicaid in most states unless they had a disability. Beginning in 2014, adults in this category whose incomes are at or below 138% of federal poverty will be eligible for Medicaid if their state chose to participate in this expansion. 42 U.S.C. § 1396d(y) (2012); *Nat'l Fed'n of Indep. Bus.*,

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[7] In 2014, the tax is the lesser of $95 or 1% of taxable income. 26 U.S.C. § 5000A(c)(2)(B)(i), (c)(3)(B) (2012). In 2016, the tax increases to $695 or 2.5% of taxable income. *Id.* § 5000A(c)(2)(B)(iii), (c)(3)(D) (2012).

132 S. Ct. at 2607 (making Medicaid expansion a state option).

Currently, 28 states and the District of Columbia have chosen to expand Medicaid eligibility under the ACA. *State Decisions*, *supra*. Those living between 100 and 138% of poverty in states that do not expand may purchase coverage on the Exchanges and qualify for premium tax credits and cost-sharing reductions. 26 U.S.C. § 36B(b)(3)(A) (2012); 42 U.S.C. § 18071(c)(2) (2012). About 1.3 million low-income pre-Medicare adults who did not have employer-sponsored health insurance in 2012 had incomes between 100 and 138% of poverty. *Effect of Health Reform*, *supra*, 7 fig. 2. These low-income pre-Medicare adults could qualify for Medicaid or, if their state of residency is not expanding Medicaid eligibility, for tax credits on the Exchanges.

Considering the reforms discussed above (and others not discussed here), the CBO and Joint Committee on Taxation project that by 2025, 27 million more people under the age of 65 will have insurance coverage than would have had without the ACA. Cong. Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline*, tbl. B-2 (2015) [*CBO January 2015 Baseline*]. These gains in coverage represent a 9.4% decrease in the uninsured rate due to ACA reforms, the vast majority of which will result from insurance purchases on the Exchanges. *Id.* (24 million will be insured through purchases on the Exchanges and 16 million through Medicaid and CHIP).

IV. Premium Tax Credits Were Meant to Incentivize Individuals, Not States.

The text and structure of the ACA support the conclusion that premium tax credits were provided to incentivize *individuals to participate* in the individual health insurance market, not to incentivize states to establish Exchanges. Like the individual mandate and the federal tax enforcing it, *see* 26 U.S.C. § 5000A(b), premium tax credits are directed at individuals and enforced through federal mechanisms. The amount of the credit depends on the individual's household income. 26 U.S.C. § 36B(b)(3)(A)(i) (2012). Additionally, premium credits are available as an advance payment to the individual or are payable directly to the individual's insurer as a refundable federal income tax credit. 26 U.S.C. § 36B(f) (2012); 42 U.S.C. § 18082(c) (2012).

Petitioners cite no credible authority for their proposition that Congress intended to use premium tax credits to "induce states to act" to establish Exchanges. Pet'rs' Br. 40-41. Instead, Petitioners argue that "legislative history is irrelevant" because the text that they allege limits premium tax credits is "plain" and "causes [no] objective absurdity." Pet'rs' Br. 39 (emphasis removed). One claim begs the question and the other based on faulty premises. Petitioners read four words in the Act out of context (ignoring various provisions that give additional meaning to these words) and in doing so create the most absurd result—dismantling the very reforms that the Act was written to effectuate. *See infra* Parts V and VI. Additionally, Petitioners speculate

that there was little discussion of Federally Facilitated Exchanges in the legislative record "*likely* because the consensus was that states would establish their own." Pet'rs' Br. at 40 (emphasis added). But such speculation is unnecessary when one considers the detailed provisions in the Act regarding the operation of Exchanges, as they show that Congress structured the Federally Facilitated Exchanges to function in the same way as the State-established Exchanges, including the function of pricing premiums based on income qualification for premium tax credits. *See* 42 U.S.C. § 18041(c)(1) (2012) (directing the Secretary of HHS to "establish and operate *such* Exchange" if the state failed to do so) (emphasis added); § 18031(d)(4) (detailing the minimum functions of "[a]n Exchange," including electronic calculation of the actual cost of coverage after the application of premium tax credits and cost-sharing reductions); *see also* Resp'ts' Br. 25.

Finally, Petitioners claim that "what history does exist" supports their argument that Congress intended to use premium tax credits to induce states to establish Exchanges. Pet'rs' Br. 41. But this one-sided view of "history" is incomplete and out of context. The cited draft proposal of the Health Education Labor and Pensions Committee, S. 1679, explicitly stated that, as a condition of eligibility for tax credits, states must establish their own Exchanges. S. 1679, 111th Cong. § 3104(a), (d) (2009). In contrast, the ACA does not contain such an expressly confining condition. Petitioners suggest that the ideas in the S. 1679 proposal were borrowed from Timothy S. Jost. Pet'rs' Br. 41. However, they

fail to point out that, in the cited article, Professor Jost also made two other suggestions of how Congress could incentivize states to establish Exchanges, that these other suggestions do not condition tax credits on the establishment of state Exchanges, and that these other suggestions *do appear* in the text of the ACA. *See* Timothy S. Jost, *Health Insurance Exchanges: Legal Issues* 7 (2009) ("Congress could invite state participation in a federal program, and provide a federal fallback program to administer exchanges in states that refused to establish complying exchanges [or offer] explicit payments to states that establish exchanges conforming to federal requirements."); *cf.* 42 U.S.C. §§ 18041(c) (2012) (providing a federal fallback program to administer exchanges in states that refuse to establish their own), 18031(a) (providing grants to states that establish their own exchanges).

In the end, what the history shows is that a proposal to condition premium tax credits on states establishing Exchanges never made it out of Committee, but the idea of establishing federal fallback Exchanges that would function in the same way as State Exchanges was enacted into law.[8]

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[8] Though Jonathan Gruber's statements of opinion made after the passage of the ACA are no evidence of Congressional intent, Petitioners rely on these statements to support their claim that Congress intended to use premium tax credits to incentivize states to establish Exchanges. Pet'rs' Br. 4-5, 42-43. Not only is their reliance on these statements inapposite, but the statements were taken entirely out of context and, thus, do not support the argument. To ensure that his comments were interpreted in the relevant contemporaneous context, Gruber

Congress may have created other incentives for states to establish Exchanges, *see, e.g.*, 42 U.S.C. § 18031(a) (authorizing federal grants to states), but the individual premium tax credit is not one of those incentives.

V. Premium Tax Credits are Essential to the Act's Primary Purpose—Achieving Access and Affordability for *All*.

Analysis of the available data on insurance purchases on the Exchanges coupled with analyses of the potential effects of eliminating premium tax credits in the 34 states with Federally Facilitated Exchanges confirm what Congress knew when it structured the ACA's interlocking reforms: premium tax credits are essential to achieving the Act's primary purpose of achieving access and affordability for *all*. If premium tax credits become unavailable in the Federally Facilitated Exchanges, health insurance will once again become unaffordable for

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testified that he was referring to "the possibility that the federal government, for whatever reason, might not create a federal exchange. If that were to occur, and only in that context, then the only way that states could guarantee that their citizens would receive tax credits would be to set up their own exchanges." Jonathan Gruber, *Written Testimony of Professor Jonathan Gruber before the Committee on Oversight and Government Reform, U.S. House of Representatives, December 9, 2014*, at 2 (2014), http://goo.gl/nlXHpO; *see also* Jonathan Gruber at Noblis, at 31:26-32:23, Jan. 18, 2012, http://goo.gl/lkNrFs (including portion of video omitted from Petitioners' citation). If the Court is inclined to consider Mr. Gruber's opinion, it should consider his full opinion as expressed in sworn testimony.

millions in the private individual market including those who do not qualify for premium tax credits—drastically reducing access and affordability for *all*.

A. If Premium Tax Credits Are Eliminated on the Federally Facilitated Exchanges, Health Insurance Will, Once Again, Become Unaffordable and Inaccessible for Millions of Low- to Moderate-Income Americans.

1. Those Who Qualify for Premium Tax Credits Will Find Insurance Unaffordable and Become Uninsured.

Millions would lose premium tax credit assistance and become uninsured if the Court accepts the Petitioners' acontextual interpretation of the Act. In the initial 2014 enrollment period, 4.7 million (86%) of those who selected a plan via Federally Facilitated Exchanges did so with premium tax credit assistance. U.S. Dep't of Health & Human Servs., *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period: October 1, 2013 -- March 31, 2014*, at 19 (2014) [*Initial Enrollment Report*], http://goo.gl/w1BlS5.[9] During the first two months of

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[9] Over 6.6 million people qualified for premium tax assistance on all the Exchanges, surpassing the CBO's estimate by 1.6 million. *Initial Enrollment Report*, *supra*, 19; Cong. Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014* at 10

the 2015 open enrollment period, another 6.1 million (87%)[10] of those who selected a plan on the Federally Facilitated Exchanges qualified for premium tax credits. *See* U.S. Dep't of Health & Human Servs., *Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report For the Period: November 15, 2014 – January 16, 2015*, at 3, 25-26 tbl. B4 (2015) [*2015 Open Enrollment January Report*], http://goo.gl/PlD1i2.

Because 2015 open enrollment is ongoing and because the availability of tax credits affects market competition and affordability on the Exchanges, various studies have attempted to model the effects of losing premium tax credits in the 34 states with Federally Facilitated Exchanges based on available data and other assumptions. One such study concluded that an estimated 9.3 million people will lose premium tax subsidies in 2016. Linda J. Blumberg, et al., Urban Inst., *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in King v. Burwell* 2 (2015) [*Characteristics*

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tbl. 3 (2014). The CBO did not differentiate between State Exchanges and Federally Facilitated Exchanges.

[10] This percentage was calculated for 37 states to include the three states that have State Exchanges but use the Healthcare.gov platform (Nevada, New Mexico, and Oregon). *See 2015 Open Enrollment January Report*, *supra*, 3, 25-26 tbl. B4. When one excludes enrollment in those states, the percentage remains the same. *Id.* The 6.1 million figure also excludes those three states. *Id.*

of Those Affected].[11] Of those, two thirds will become uninsured. *Id.* 2-3. The 1.1 million who are in the lowest income bracket for tax credit eligibility—100 to 138% FPL—will be most adversely affected when they become uninsured, as they are living in states that did not expand Medicaid eligibility under the ACA and thus will not have other alternatives for affordable coverage. *Id.* 3-4 tbl. 1.

2. The Effectiveness of the Individual Mandate in Increasing and Diversifying the Insurance Risk Pool Will Be Significantly Hampered, Making Health Insurance Less Affordable for Everyone in the Private Individual Insurance Market.

The function of the individual mandate, to increase the number of insured, would be

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[11] "Estimates presented in this analysis reflect effects at a point in time, and therefore understate the number of people who would be affected over the course of a year and over multiple years...." *Id.* Though the long-term effects of eliminating tax credits on the Federally Facilitated Exchanges are nearly impossible to predict, there are some projections that shed light on the magnitude of the potential impact. *See e.g.*, *CBO January 2015 Baseline*, *supra*, tbl. B-3 (not differentiating between State and Federally Facilitated Exchanges, the CBO projected that by 2018, 19 million will purchase insurance on the Exchanges with the assistance of premium tax credits); Kaiser Family Found., *Marketplace Enrollees Eligible for Financial Assistance as a Share of the Subsidy-Eligible Population, April 2014* (Apr. 19, 2014), http://goo.gl/EQ4iAZ (last visited Jan. 28, 2015) (an additional 10.5 million people qualified for tax credits during the 2014 open enrollment period, but did not enroll).

significantly weakened if premium tax credits were eliminated in states with Federally Facilitated Exchanges. Insurance premiums will become unaffordable for millions who may then qualify for the unaffordability exemption to the individual mandate or may opt to pay the tax penalty for choosing to forgo coverage. *See* 26 U.S.C. § 5000A(e)(1)(A) (2012) (exempting individuals from obtaining coverage when the cost of coverage exceeds 8% of household income); *see also* 26 U.S.C. § 5000A(c) (providing the tax penalty amounts for not purchasing coverage). Though some of those loosing tax credits would retain health insurance, either at higher premium prices or through alternative methods of gaining coverage (*e.g.*, post-retirement employment to gain employer-based coverage), almost all of them (99%) would face premiums in the individual market deemed unaffordable under the ACA. *See Characteristics of Those Affected* 3, 7; *see also* 26 U.S.C. § 5000A(e)(1)(A); *2015 Open Enrollment January Report* 22-24 tbl. B3 (96% of those who applied for coverage were eligible for premium tax credits).

Most of those who would become uninsured if premium tax credits were eliminated reported being in excellent, very good, or good health. *Characteristics of Those Affected* 3, 6 (90.3% of those losing tax credits and 92.1% of those with higher incomes and ineligible for tax credits reported good or better health). Consequently, these healthy people are less likely to retain insurance that is significantly more expensive. *Id.* 3 (67.9% of those in good or better health will drop coverage compared to 58.2% of

those in fair or poor health). Without the ability to attract more healthy people to the insurance risk pool in states with Federally Facilitated Exchanges—as tax credits currently do by reducing premiums by an average of 76%—there would be fewer insurance providers in the individual market thus reducing competition and increasing premiums. *See* Amy Burke et al., U.S. Dep't of Health & Human Servs., *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014*, at 2, 17-18 (2014). Premiums may increase by 35 to 47 percent. Evan Saltzman & Christine Eibner, Rand Corp., *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* 2 (2015) [*The Effect of Eliminating Tax Credits*]; *Characteristics of Those Affected*, *supra*, 3. This effect will be more pronounced in states that use Federally Facilitated Exchanges because those states have higher proportions of low-income residents, had higher rates of uninsured residents prior to implementation of the ACA, and most did not pursue Medicaid Expansion under the ACA. *Id.* 6.

The rising costs of health insurance premiums will affect everyone in the individual market—in State Exchange markets, in plans sold outside of the Exchanges, and even for those who have higher incomes that make them ineligible for tax credits. One study estimated that changes in premium prices would make 3% of those who purchased health insurance on the State Exchanges eligible for the unaffordability exemption to the individual mandate. Larry Levitt & Gary Claxton, Kaiser Family Found., *The Potential Side Effects of Halbig* (Jul. 31, 2014),

http://goo.gl/GECcHt. Another study found that "[e]nrollment in the ACA-compliant individual market, including plans sold outside of the marketplaces that comply with ACA regulations, would decline by 9.6 million." *The Effect of Eliminating Tax Credits*, *supra*, 2. Others have estimated that 1.2 million people who would pay full-price for their premiums will be uninsured because premiums will become unaffordable. *Characteristics of Those Affected*, *supra*, 3.

3. Coverage Losses in Public and Group Insurance Markets Will Undermine the Goal of Near-Universal Coverage.

Not surprisingly, eliminating tax credits that are so central to affordability and access—and thus to achieving near-universal coverage—in the individual insurance market will impact other insurance markets as well. A sort of "reverse woodwork" effect will occur when people who would otherwise go to Federally Facilitated Exchanges to investigate whether they are eligible for tax credits no longer do so and, in the process, forgo discovering that they and/or their family members are eligible for publicly-funded insurance. *Id.* at 6 (estimating that 445,000 individuals fall into this category). Additionally, changes in nongroup insurance premiums will affect decisions about whether to offer and accept employer-based group coverage. *Id.* (estimating that 300,000 individuals fall into this category). Taking all of these effects into consideration, by one estimate, the number of

uninsured people would increase by 8.2 million in 2016. *Id.*

B. Eliminating Premium Tax Credits on the Federally Facilitated Exchanges Will Disproportionately Impact Low- to Moderate-Income Pre-Medicare Adults.

Older adults comprise nearly half of those who enrolled for individual health insurance coverage through Federally Facilitated Exchanges. *Initial Enrollment Report*, *supra*, 20 tbl. B1 (22% ages 45 to 54 and 25% ages 55 to 64); *2015 Open Enrollment January Report*, *supra*, 12 tbl. A1 (22% ages 45 to 54 and 27% ages 55 to 65). Premium tax credits will be especially important to pre-Medicare adults, given their historic difficulty accessing affordable coverage. For example, one study estimates that tax credits will reduce the cost of monthly premiums by $433 (69%) for a Silver Plan for a 60-year-old with income at 250% of the FPL in Indianapolis, Indiana (a state with a Federally Facilitated Exchange). *See* Cynthia Cox et al., Kaiser Family Found., *An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014*, at 6 (2013). Without premium assistance, this 60-year-old could pay $626 per month for this plan, representing 26% of her monthly income.[12] Given the high cost of insurance relative to income, this 60-year-old may opt to forgo

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[12] Two hundred and fifty percent of the FPL in 2013, when this study was conducted, is an annual income of $28,725 and a monthly income of about $2,394. *See* Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5,183 (Jan. 24, 2013).

health insurance altogether and seek an affordability exemption. *See* 26 U.S.C. § 5000A(e)(1)(A) (the unaffordability exemption is available when the cost of coverage exceeds 8% of household income). This example illustrates that, for low- to moderate-income people, assistance with their premiums will be the difference between coverage that is affordable and coverage that is out of reach. Indeed, 38.5% of those who would lose tax credits and become uninsured are between the ages of 45 and 64, a rate higher than any other age group. *See Characteristics of Those Affected*, *supra*, 2, 4 tbl. 1.

VI. Eliminating the Availability of Premium Tax Credits in 34 States Will Cannibalize the Act's Key Reforms and Jeopardize Lives.

The availability of premium tax credits in *all* states is essential to achieving the ACA's central purpose. This is evident not only from the effect that the elimination of premium tax credits has on affordability, both in terms of individual affordability and the overall effect it has on premium prices in the insurance markets, but also from the effect it has on many other reforms central to the ACA.

A. Eliminating the Availability of Premium Tax Credits in 34 States Will Render Other Interconnected ACA Reforms Meaningless.

All other ACA reforms designed to make coverage more accessible, such as the guaranteed

issue provisions and limitations on age rating, will be meaningless to those who cannot afford the premiums. *See supra* Parts III.B.1-3. Moreover, eliminating assistance with premiums in the 22 states with Federally Facilitated Exchanges that are also not expanding Medicaid eligibility means that low-income residents in these states will not have new options for affordable coverage. *See supra* Parts III.B.4 and V.A.1; *see State Decisions, supra.* Additionally, according to Petitioners' interpretative theory, employers in 34 states would be able to evade the employer mandate simply because their state chose not to establish its own Exchange—thus eliminating another important reform designed to increase access to affordable care. *See supra* Part III.B.1. It is implausible, to say the least, that Congress intended to allow the entire Act to be cannibalized by a state's choice not to establish its own Exchange.

B. Premium Tax Credits, and the ACA, Have Saved the Lives of Pre-Medicare Adults Who Were Previously Uninsured, Underinsured or Denied Adequate, Affordable Health Insurance Due to Their Age or Preexisting Conditions.

Premium tax credits don't just make insurance affordable and make other ACA reforms work—they save lives. Among the pre-Medicare adults who credit the ACA with saving their lives is Lisa Gray, a 62-year-old small business owner in Alexandria, Virginia, who obtained affordable coverage just in

time to receive the treatment that eradicated a rare leukemia discovered during an unrelated visit to the emergency room. *See* Noam N. Levey, *Obamacare's Guaranteed Health Coverage Changes Lives in First Year*, LA Times, Jan. 4, 2015, http://goo.gl/AqDqQ3. Like many pre-Medicare adults prior to the implementation of the ACA, Lisa bought an expensive insurance plan on the individual market that did not provide sufficient coverage. She was paying $1,095 per month in premiums, but her plan covered only $1,500 of the $6,809 monthly cost of the life-saving oral chemotherapy that her doctor prescribed. *Id.* Though she tried desperately to find a way to pay for the drug, she earned too much to qualify for public insurance or the assistance programs offered by drug companies, and she could not seek another insurer because she would be denied coverage due to her preexisting condition. *Id.* After months of finding ingenious ways to finance her treatment or sometimes suffering the consequences of going without it, she finally obtained health insurance through Healthcare.gov for $315 less in premiums and only $30 per month co-pay for her prescription. *Id.* Lisa was now able to afford the drug that her doctor prescribed and within nine months her biopsy showed no signs of leukemia. *Id.*

The life-saving power of affordable health insurance does not discriminate based on politics or ideology. Dean Angstadt—a 57-year-old, self-employed logger who self-insured and who opposed the ACA—personally experienced that power when he enrolled for health insurance through Healthcare.gov just in time to have the aortic valve

replacement surgery that he could not afford and that saved his life. *See* Robert Calandra, *Once Opposed to ACA, Now a Convert*, Philadelphia Inquirer, Apr. 28, 2014, http://goo.gl/D48Cgt. His first monthly premium was only $26.11. *Id.* As someone who had the ability to obtain affordable, life-saving health insurance with the assistance of premium tax credits in a state with a Federally Facilitated Exchange, and commenting on the politics surrounding the ACA, Dean stated: "From my own experience, the ACA is everything it's supposed to be and, in fact, better than it's made out to be." *Id.* Though some who are politically opposed to the ACA question whether saving lives is worth the cost, that cost-benefit analysis was rightfully done by Congress. *See, e.g.*, Michael F Cannon, *New Study Suggests RomneyCare Saved Lives, But at a Very High Cost*, Forbes, May 5, 2014, http://goo.gl/FyRr0W. Congress decided to provide federal tax assistance to low- to moderate-income people in order to effectuate the purpose of the Act to make affordable, lifesaving, health insurance accessible to all—not just to those whose state leaders share their political views.

CONCLUSION

Premium tax credits are critical to ensuring that *all* Americans, and in particular pre-Medicare adults, have access to adequate, affordable health insurance, and thus health care. Reading the ACA to limit premium tax credit eligibility only to people who live in states that operate an Exchange will make insurance unaffordable and inaccessible to millions of low- to moderate-income Americans in the

34 states with Federally Facilitated Exchanges and even to those who do not qualify for the tax credits, will cannibalize the Act's key reforms, and will put countless lives in jeopardy—results that are plainly contrary to the purpose the ACA. Because Petitioners' limitation on the availability of premium tax credits would "bring about an end completely at variance with the purpose of the statute," it must be rejected. *United Steelworkers v. Weber*, 443 U.S. 193, 202 (1979) (statutory prohibition on discrimination "because of race" did not prohibit voluntary race-based affirmative action). The Fourth Circuit Court of Appeals' ruling should be affirmed.

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